Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
J. S. Harris

Respondent Name
Sentry Insurance A Mutual Co

MFDR Tracking Number
M4-14-2820-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 13, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are asking that these claims be processed for payment by the carrier. The carrier has accepted that the injury is compensable. These services do not require any pre-authorization. Each and every one of the dates of service has documentation to support the service billed."

Amount in Dispute: $450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: DWC Rule 134.600(p)(12)states that all treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols, etc. require preauthorization. It is Respondent's position that the office visits performed by the Requestor more than 9 years after the date of injury exceed the commissioner's adopted treatment guidelines, the Official Disability Guidelines (ODGs), are therefore, required preauthorization. It should also be noted that, although the Requestor did not bill for it, the medical records indicated that the Requestor was also performing manipulations and traction on the Claimant during each visit. These procedures also would require preauthorization. In conclusion, no reimbursement is owed as the Requestor failed to seek preauthorization for the treatment prior to performing the treatment.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2013 through December 26, 2013	99213	$450.00	$450.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 249 – Denied per customer request
   - 249 – This service or supply has been reviewed in accordance to the prevailing fee schedule guidelines or

Medicare standards
- C – Description not Available
- 892 – Billed date exceeds 95 days from date of service

Issues

1. Did the respondent meet requirements of 28 Texas Administrative Code §133.307?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
3. What is the applicable rule pertaining to reimbursement.
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent states, "In conclusion, no reimbursement is owed as the Requestor failed to seek preauthorization for the treatment prior to performing the treatment." Review of the denial reasons show nothing to support the carrier denied for prior authorization. Applicable 28 Texas Administrative Code §133.307(d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented this denial reason prior to the request for MFDR. The Division concludes that the carrier raised a new denial reason. For that reason, the carrier's position regarding the prior authorization shall not be considered in this review
2. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99213 is: "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, **15** minutes are spent face-to-face with the patient and/or family."

   The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

   - Documentation of the Expanded History
     - History of Present Illness (HPI) consists of one to three elements of the HPI. Documentation found listed one chronic condition, thus meeting component.
     - Review of Systems (ROS) inquires about the system directly related to the problem(s) identified in the HPI. Documentation found listed one system. This component was met.
     - Past Family, and/or Social History (PFSH) are not applicable.
   - Documentation of a Expanded Examination:
     - Requires limited examination of the affected body area. The documentation found examination of four systems: neck, each extremity, musculoskeletal, neurological. This component was met.
   - Final result for complexity – Minimal – low
   - Level of service based on time is not applicable.

   The division concludes that the documentation sufficiently supports the level of service billed.

3. Procedure code 99213, service dates November 19, 2013 through December 26, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.97873.

The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 1.017 is 1.1187. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.834 is 0.05838. The sum of 2.15581 is multiplied by the Division conversion factor of $55.30 for a MAR of $119.22. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $50.00 x 9 = $450.00

4. The total allowable reimbursement for the services in dispute is $450. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $450.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $450.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $450.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 20, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.